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Testimony of Jeanne Milstein, Child Advocate
Human Services Committee
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Senator Doyle, Representative Walker, and Members of the Human Services Committee. Thank you for the opportunity to testify about HB 6525, An Act Establishing a Task Force to Study Reorganization of the Department of Children and Families and to testify in opposition to HB 6523, An Act Concerning Licensing of Adolescent Substance Abuse Treatment Facilities..

The bill includes two charges for the task force. The first charge would be to evaluate the department's current policies, practices and procedures including whether DCF may suspend visitation prior to a court hearing. Connecticut General Statutes § 17a-10a currently requires that DCF ensure that any child in the care and custody of the department under an order of temporary custody or an order of commitment is "provided visitation with such child's parents and siblings, unless otherwise ordered by the court." In my view, this language already requires that DCF seek a court order prior to suspending visitation and is the appropriate policy. If the committee's goal is to ensure that visits are not suspended without a court hearing, I would suggest consideration of modification of section 17a-10a of the General Statutes to clarify that such a hearing is required, rather than charging a task force to review the issue.

The second charge of the task force would be to consider changes in the structure of DCF. As I testified at the investigative hearings regarding DCF in October and November, I believe DCF is an agency in peril. I agree that bold action must be taken. I would urge you, however, to move beyond the idea of structural change of the Department and look at whether DCF has the right people with the right skills in the right positions to effect badly needed fundamental change.

There are pockets of progress at DCF. Much of this progress, however, has occurred in the context of a crisis or in response to external pressure, rather than as a result of ongoing systematic efforts of self-evaluation and improvement. For example, much of the progress made over the last decade has been in response to the constant scrutiny of the Juan F. Consent Decree and Exit Plan. Last summer, DCF was on the brink of federal receivership because of sustained noncompliance with the Juan F. outcome measures. Only under the threat of receivership did DCF decide to conduct a high level review of all children with no hope of ever living with a family [those with a permanency goal of Another Planned Permanent Living Arrangement (APPLA)] or to finally release a plan to recruit and retain the necessary pool of foster homes. Only under pressure from OCA did DCF close Lake Grove last fall, despite nearly a decade of persistent and known concerns about the health, safety, and well-being of children placed at the facility. And most recently, only in response to the tragic death of Michael B. did DCF take action to stop the practice of keeping paper files on DCF employees accused of abuse rather than entering those cases into the DCF database as required in every other case.

I am gravely concerned about the chronic and substantially similar patterns of deficient leadership and management, inadequate oversight, and poor long-term planning for individual children and for all children and families served by DCF found in investigations and evaluations

by my office and numerous others including the Office of the Attorney General, and the Legislative Program Review and Investigations Committee.

I am equally troubled by the persistent slow pace of implementation of much needed change. During my tenure as Child Advocate, I investigated the harmful conditions for children at Haddam Hills, the Connecticut Juvenile Training School (CJTS), Riverview Hospital, and more recently at Lake Grove and Stonington Institute, and found that DCF was often aware of these conditions and failed to act to protect children. These investigations reveal repetitive and similar problems and inadequate response. They also confirm that many of the people in leadership positions at DCF during these crises continue to guide the agency in leadership positions today. After seventeen years under the Juan F. Consent Decree, the 2008 CFSR preliminary findings still rate DCF significantly below national standards for permanency outcomes and raise significant concerns about work quality being driven by individual staff rather than an agency-wide practice model.

During the past two years, OCA has raised concerns about DCF's process related to the implementation of a statewide Differential Response System (DRS) in 2009. DCF initiated its most recent effort in 2006 without a careful look at the reasons for the failure of its citywide DRS pilot in 2003. In 2004, evaluators concluded that the pilot failed and cited changes in leadership related to reorganization at DCF, the lack of clear accountability mechanisms, and inadequate involvement and commitment of community-based providers as reasons contributing to failure. These factors continue to exist today as DCF moves forward with a statewide DRS initiative.

In the three years since DCF's own consultants cited an urgent and compelling need to create a continuum of services for girls, the most tangible girls initiative is a plan for an 18-bed secure facility for delinquent adolescent girls. Almost no planning has gone into developing the continuum of services that is so desperately needed and recommended by numerous experts and stakeholders. Last summer, my office released a report revealing the child welfare to prison pipeline. Over a two year period, 325 girls under age eighteen were admitted to Connecticut's maximum-security prison for adult women. Our investigation found that over 90% of these girls had either current or historical involvement with DCF, a significant number with DCF cases that had been closed within the year prior to incarceration. And nearly 98% of these girls entered and remained in adult prison without ever being convicted of a crime. My staff also discovered that DCF has been noncompliant with its own policies related to incarcerated girls and its memorandum of understanding with the Department of Correction. While Commissioner Lantz promptly responded and sent a detailed action plan for the Department of Correction, DCF's response has been unsatisfactory.

For all of these reasons, I believe that today's DCF is an agency in peril. It has suffered from a chronic lack of effective leadership and management, at all levels and across all bureaus. Until this deficiency is corrected, DCF will continue to struggle to meet the needs of children and families and those children and families will suffer the consequences.

I have great concerns, however, about the bill as written and recommend today, as I did during the investigative hearings in October and November, that the legislature conduct a broad and

deep leadership audit rather than focusing on structural change. I see no reason to believe that structural change alone, including removal of certain statutory mandates, can transform ineffective managers into effective leaders that can execute and sustain fundamental change in outcomes for our children. If anything, separately housing the programs and services needed to assess and address the needs of a "whole" child requires an even greater confidence in leadership talent to communication and collaborate across state agencies. A leadership audit, as outlined in HB 6420, An Act Concerning a Leadership Audit of the Department of Children and Families, would be a focused look at leadership at all levels to ensure that the agency has the right people with the right skills in the right places to bring about the kind of fundamental change that is needed. Rather than focusing on structure, it would focus on making sure those in charge have the skills, training, experience, and talent to get the job done. This kind of analysis of DCF has never been done and I believe it is the critical next step and the most effective action that we can take to address the agency's long-standing pattern of failure.

I oppose HB 6523, An Act Concerning Licensing of Adolescent Substance Abuse Treatment Facilities. Currently, substance abuse treatment facilities for children and youth are dually licensed, both by the DCF and the Department of Public Health (DPH). This bill as written would exempt such facilities from licensure by DCF but does nothing to transfer the licensing responsibilities currently administered by DCF from DCF to DPH. Given that the present DPH licensing role is very narrow, the bill as written would leave significant gaps in licensing and oversight, placing children at risk of harm.

In the course of more than one investigation conducted by my office, we have learned that DPH facilities inspectors take a very narrow view of DPH's licensing responsibilities. Our investigation of Stonington Institute is demonstrative. Our investigation revealed serious concerns, including lack of adequate medical care and involuntary intramuscular injections of medication. While DPH took action with regard to some violations, DPH facilities inspectors viewed DPH's role as limited to substance abuse treatment only. This is significant because substance abuse facilities for children and youth necessarily include components not involving substance abuse treatment as defined by DPH. It is not wise or good policy to remove the present DCF licensing authority without transferring it to another agency. Given the potential risk of harm to children, I oppose HB 6523.

I would encourage, however, a deeper look at licensing of programs and facilities that provide care and treatment to children. Providers find that they often must obtain a license from more than one agency. Multiple inspectors from different agencies inspect the facilities. Communication between the various inspectors is lacking and inspectors from one agency often presume that inspectors from a different agency are responding to inadequacies outside of their purview. Some inspectors do not have appropriate training, skills, or experience. I would encourage you to consider methods to improve the quality of licensing and oversight; identify areas of overlap and methods to increase efficiency in the licensing process, both from an administrative and provider point of view; and ensure that those charged with licensing have appropriate expertise. I would be happy to work with the Committee on such an endeavor.

Thank you.